



ROBERT D. COOK, M.D., P.A.  
 DIPLOMATE AMERICAN BOARD OF ALLERGY AND IMMUNOLOGY

4150 NORTH LAMAR • AUSTIN, TX 78756  
 PH: (512)467-0978 • FX: (512)467-8066  
 centraltexasallergy.com

TODAY'S DATE:		<b>PATIENT INFORMATION</b>			
FIRST NAME		MI	LAST NAME		DOB
ADDRESS			CITY	STATE	ZIP
HOME PHONE	WORK PHONE	OTHER / BEEPER / MOBILE		E-MAIL	
SS#	DL#	SEX: M( ) F( )	AGE	MARITAL STATUS S( ) M( ) W( ) SEP( ) D( )	
PATIENT'S EMPLOYER		WORK FULL TIME? Y( ) N( )		FULL TIME STUDENT? Y( ) N( )	
BUSINESS ADDRESS				OCCUPATION	

REFERRED BY		ADDRESS (IF MD)	
PRIMARY CARE PHYSICIAN		ADDRESS	
IN CASE OF EMERGENCY, NOTIFY		WORK/CELL PHONE	RELATIONSHIP TO PT
SPOUSE'S NAME	DOB	WORK/CELL PHONE	EMPLOYER

PRIMARY INSURANCE COMPANY NAME		
NAME OF POLICY HOLDER	RELATIONSHIP TO PATIENT	POLICY HOLDER SS #
CERTIFICATE OR POLICY #	GROUP #	POLICY HOLDER DOB
SECONDARY INSURANCE COMPANY NAME (Circle <b>NONE</b> IF NOT APPLICABLE)		
NAME OF POLICY HOLDER	RELATIONSHIP TO PATIENT	POLICY HOLDER SS #
CERTIFICATE OR POLICY #	GROUP #	POLICY HOLDER DOB

**IF PATIENT IS A MINOR OR A FULL TIME COLLEGE STUDENT:**

MOTHER'S NAME		DOB	SS #
HOME ADDRESS		CELL PHONE	HOME PHONE
OCCUPATION	EMPLOYER		WORK PHONE
FATHER'S NAME		DOB	SS #
HOME ADDRESS		CELL PHONE	HOME PHONE
OCCUPATION	EMPLOYER		WORK PHONE

RESPONSIBLE PARTY FOR PAYMENT (please circle)  
 SELF, MOTHER, FATHER, OTHER (If Other, list Name, Relationship to Patient, Phone & Address)

In order to control our costs of billing, we request that office visits be paid at the time service is rendered. We would rather control our billing costs than be forced to raise our fees.

G:\FrontOfficeMasters\NewPatientForms\ptinfo.doc\120709

**SIGN:** \_\_\_\_\_ **DATE:** \_\_\_\_\_



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Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

### MEDICATIONS

Please list **ALL** current medications

Strength and when taken

1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____
11. _____	_____
12. _____	_____

### PLEASE LIST ALL FOOD AND MEDICATION ALLERGIES:

Food or Medication	Reaction (hives, swelling, anaphylaxis, etc)	Approx age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you tried the following medications

Were they effective?

1. Claritin	Yes / No	Yes / No
2. Allegra	Yes / No	Yes / No
3. Zyrtec	Yes / No	Yes / No
4. Flonase	Yes / No	Yes / No
5. Nasonex	Yes / No	Yes / No
6. Nasacort	Yes / No	Yes / No

### SURGERIES/HOSPITALIZATIONS

Surgery/hospitalization

Year

1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____



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### **HIPPA ACKNOWLEDGMENT**

Please initial the following:

\_\_\_\_\_ I acknowledge that **Robert Cook, M.D., P.A.** has provided me with a written copy of the Notice of Privacy Practices and that I have been afforded the opportunity to read the Notice of Privacy and ask questions.

### **FINANCIAL POLICY AGREEMENT**

\_\_\_\_\_ For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

\_\_\_\_\_ I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

### **MEDICAL RECORD RELEASE**

\_\_\_\_\_ I authorize the release of any medical or other information necessary to process medical claims made to my health insurance plan. I also authorize payment of benefits by my health insurance company, to Dr. Robert Cook or to Central Texas Allergy & Asthma Center.

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### **PATIENT CONTACT INFORMATION**

1. Please list the family members or other persons whom we may inform about general medical conditions or your diagnosis:

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

2. Please list phone numbers where we may leave confidential messages

\_\_\_\_\_ NONE \_\_\_\_\_ HOME \_\_\_\_\_ WORK/CELL

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### **E-PRESCRIBE AUTHORIZATION**

As of September 1, 2010 Dr. Cook's office began using E-Prescribe. I have been informed of E-Prescribe.  \_\_\_\_\_ (patient initials). I  grant /  do not grant permission that my full prescription history may be downloaded for review by Robert D. Cook, MD and his staff.

Signature  patient  guardian \_\_\_\_\_

Date \_\_\_\_\_

Printed Name \_\_\_\_\_

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### **PATIENT/AUTHORIZED PERSON'S SIGNATURE**

Signature  patient  guardian \_\_\_\_\_

Printed Name \_\_\_\_\_

Date \_\_\_\_\_